COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

IN RE: BEHAVIORAL HEALTH TECHNICAL ADVISORY COMMITTEE

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January 6, 2021
2:00 P.M.
(All Participants Appear Via Zoom or Telephonically)

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APPEARANCES

Sheila Schuster
CHAIR

Michael Barry
Gayle DiCesare
Sarah Kidder
Valerie Mudd
Steve Shannon
TAC MEMBERS

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APPEARANCES
(Continued)

Stephanie Bates
Angela Parker
Jessin Joseph
Sharley Hughes
MEDICAID SERVICES

Court Reporter's Note: At the request of DMS, all other participants appearing via Zoom or telephonically will not be listed under Appearances.)

AGENDA

DR. SCHUSTER: All of our voting TAC members are here, so, I'm going to call the meeting to order and introduce myself. I'm Sheila Schuster. I'm the Executive Director of the Kentucky Mental Health Coalition and a licensed psychologist and Chair of the Behavioral Health TAC.

So, let's have the voting members say hello.

(INTRODUCTION OF TAC MEMBERS)

DR. SCHUSTER: We'd like to welcome United Healthcare, our newest MCO here in Kentucky, and I believe they have some people on - I don't know that I would recognize the names - and also the new name for Passport which is Passport Health by Molina Health Plan. Is that right, Liz?

DR. McKUNE: Yes, Passport Health Plan by Molina Healthcare.

DR. SCHUSTER: By Molina Healthcare. Okay. Thank you.

If you did not get my email about this meeting directly, I would appreciate it if you would type your name and contact information in the Chat so I can get you on. We grow the list. Typically, of those of you who used to attend in person, we would circulate a sign-in sheet. So, that

way you get the information and the followup information, and Sharley has been great about sending information out from the Department for Medicaid Services and we try to circulate that back with you all. Thank you very much.

Anything else by way of introduction? Since we have a court reporter on to take the minutes for us, if you want to add to the discussion, if you would please identify yourself for the court reporter, that would be helpful and we will go on.

I circulated the minutes from our November 4th meeting, and I would entertain a motion from one of our voting TAC members for approval of the minutes.

MS. MUDD: I so move.

MR. ESSEK: And I'll second.

DR. SCHUSTER: Who was the second?

MR. ESSEK: Daniel Essek.

DR. SCHUSTER: No. Daniel, it has to be one of the voting members of the TAC.

MR. BARRY: Mike Barry. I'll second.

DR. SCHUSTER: All right. Thank

you, Mike. Any corrections, additions, omissions? All those in favor of approving the minutes, again, just voting members of the TAC, signify by saying aye. And opposed, like sign. All right. Thank you very much.

Sharley, is Stephanie on from the Department?

MS. HUGHES: Yes, Stephanie is on. Everyone please mute except for who is speaking.

DR. SCHUSTER: Yes. Thank you. Hi, Stephanie.

MS. BATES: Hey, how are you?

DR. SCHUSTER: Fine. Happy New Year. Good to see you remotely.

So, we keep this targeted case management issue on here because it continues to be probably the number one issue for most of our providers, family members and consumers, and I didn't know if there was any update from DMS on the targeted case management issues.

MS. BATES: No, honestly, because the PA's are lifted on those right now and we don't foresee that ending anytime soon.

We have an updated (inaudible) for February 1, but, still, I don't foresee the

substance use or behavioral health PA's going back on for a while. We kind of wanted to get through the implementation of the MCOs and all of that before we started going back to the normal things that we were tackling. And since the PA's are off, we haven't really revisited those but we will.

Now, we have had just this week conversations about targeted case management more specific to DCBS and how that looks in the regs and all of that but that was more of an internal discussion.

I believe at the next Behavioral Health TAC, we will be able to give a little bit more of an update just because we've had so many other things going on.

DR. SCHUSTER: You mean you all have been a little busy here?

MS. BATES: No, no. I didn't mean to say that we were busy.

DR. SCHUSTER: Just judging from the number of documents that Sharley has to send out to all of us, I'd say that you all have been busy. And I keep that on there not really to bug you all but we really want to be part of the discussion when the time is right.

MS. BATES: Yes, and I think you'll see that that discussion will start to pop up here. Probably the latter part of the month we'll start those back but to get through the hump of January 1 and let the dust settle a little bit with regard to new MCOs and all of that and, then, we can bring you all to the table.

DR. SCHUSTER: All right. That would be great because we've shared with you some data that some of our housing and folks in Louisville shared with us. So, we have some data and we definitely want to be at the table.

We also want to show our appreciation to the Department for their continued banning of prior authorizations for behavioral health both on the mental health and on the substance use disorder side. So, please convey that to Commissioner Lee and your fellow folks over there at DMS. We appreciate that.

MS. BATES: Certainly, absolutely.

DR. SCHUSTER: I think I saw that Dr. Jessin Joseph had signed on. We did want to get an update on implementation on the single Medicaid Formulary and find out about a schedule of

P&T Committees. And also I will just add, I think that you all have awarded the PBM contract. I think I saw that.

So, if Dr. Joseph is on, if he might share some information with us, that would be great.

DR. JOSEPH: Hey, Sheila, how are you?

DR. SCHUSTER: I'm fine. Thank you, Jessin.

DR. JOSEPH: Yes, we did award the PBM contract. I'll start there. The awarded vendor was Medimpact. And, so, we're beginning discussions for the go-live date of 7/1.

In terms of the PDL, we did go live 1/1. For us, again, we're making sure that we're ensuring coverage for all members.

One of the things that we're trying to minimize is any member disruption. So, again, if there are issues, we are asking anybody to reach out directly to my office and we can definitely work with the MCOs; but at the same time, we do need everyone to follow proper protocols. So, a rejection at the pharmacy should be followed up with the appropriate protocol that the PBM and the MCO has

already set up.

So, again, we want to minimize the changes that were impacted by the single PDL. There are two that we're aware of that we want to ensure that everyone is aware of now. In terms of the diabetic supplies, I don't necessarily think it will be for very long. We should be fixing this by the end of this week.

And, then, also for products that technically are products on the Preferred Drug List but can also be over-the-counter products not always will require a prescription. So, we are working through those right now - just two caveats that we seemed to overlook when we were putting this together.

So, we'll get those done as soon as possible, but other than that, from our understanding, the less calls, the better; but certainly if something does come up, just reach out.

DR. SCHUSTER: Okay. Let me stop for just a second here and see if anyone who is on the call has had any problems since 1/1. Obviously, we haven't had a lot of days, but if some of you who run the peer-runned centers, Kelly, I'm thinking some of you at NAMI and so forth, have you

encountered anything that's a question or a problem?

MS. GUNNING: We have not, Sheila. Nothing has been reported as of yet.

DR. SCHUSTER: Good. Anybody else? Val?

MS. MUDD: I haven't heard anything.

DR. SCHUSTER: Thank you very much. I'll let people know, Jessin, to be in touch with you or they can let me know and I can let you know what we're hearing, but so far, so good. That's great.

DR. JOSEPH: And I think, Sheila, you just had one more question regarding P&T meetings. Our P&T meetings are on the third Thursday of the month. We have four of them usually a year. We list off about six of them, but due to quorum concerns with the P&T Committee, to be honest, we only end up having about four.

And, so, we schedule around March, May, September and November. So, we leave the holiday one off and, then, the summer one off. So, it's available on our website. I will share the link with Sharley to share with you all, but I did want to let you all know it looks like we have six scheduled;

but in all honesty, due to quorum and, then, some of the requirements, we've only had four in the previous years. So, four a year, just as a heads-up.

MS. MUDD: What time are those meetings? Are they at the same time or does it vary?

DR. JOSEPH: They begin at 1:00 and they usually go - they're scheduled to 4:00, depending on the number of products we're reviewing. So, sometimes it will get out early, but we block off at least three hours.

And, then, I guess due to the pandemic, right now, we are holding all the P&T meetings virtually. So, just running through a Zoom link is the easiest way right now.

MS. MUDD: So, the next one that's coming up, I'm looking at my calendar, is March 18th at 1:00. Is that correct?

DR. JOSEPH: Yes.

MS. MUDD: And, Sheila, you will send that out to us, right, so we know?

DR. SCHUSTER: Yes. Jessin will share that with Sharley and we'll get it out. I think the question, Jessin, is when do you set the agenda because you don't do every drug every meeting? So, we know you set the agenda and, of course, we're

going to be interested in any of the psychotropic medications.

DR. JOSEPH: Sure, of course. We set the agendas a few weeks out. I'll have to take a look because the antipsychotic medications themselves, we have a set month that we focus on those. So, let me go back and make sure that it is still staying the same and we'll let you know. I'll highlight that for you, Sheila, to pass along.

One thing to note is, just as an example, if an antipsychotic medication were to come out in a month that is not necessarily the month that we're going to be reviewing the entire class, we would still review that drug product. We wouldn't necessarily make that a hindrance to review.

DR. SCHUSTER: Okay. So, it's not just once a year that we get a shot at it, in other words, if something new is on the market.

DR. JOSEPH: The class in its entirety is once a year; but the new products, when they come out, we'll be a little more forward thinking on those.

DR. SCHUSTER: Right. If you will let me know what month that typically is. We're glad to be back in the proximity of the P&T Committee

again because we have been very active historically. And, then, when it got farmed out to all the different MCOs, we really lost that connection. So, we appreciate that.

And that's all I had, Jessin. Again, we really appreciate your openness to input at our last meeting and from Dr. Pinto and so forth, including the long-acting injectables because we do think that that's really the way forward for so many of our folks with severe mental illness. So, we do appreciate that very much.

MS. GUNNING: Sheila, this is Kelly. Could you repeat the name of who the contract was awarded to? I'm sorry.

MS. BATES: It'S Medimpact.

MS. GUNNING: Thank you.

DR. SCHUSTER: It had been Magellan and----

MS. BATES: No, no, no. And I apologize if my dog barks, but the fee-for-service PBM is Magellan now. Each MCO has their own PBM now, and this is a single PBM for all of the MCOs to basically use. Fee-for-service will still have their own PBM.

MS. GUNNING: Thanks, Sheila.

DR. SCHUSTER: So, the contract was for the non----

MS. BATES; The MCOs.

DR. SCHUSTER: The MCOs.

MS. BATES: That's right.

DR. SCHUSTER: Okay. Thank you. I didn't realize that. And where are they located? Do you know, Stephanie or Joseph?

MS. BATES: Joseph, do you know?

DR. JOSEPH; San Diego.

MS. BATES: We met with them this morning. I forgot because I was jealous they were in San Diego.

DR. SCHUSTER: You must have repressed that, Stephanie.

MS. BATES: I did. I just blocked it out.

DR. SCHUSTER: Okay. We're on to MCO open enrollment and lawsuit update. I guess that's you, Stephanie.

MS. BATES: So, open enrollment ended December - it seems like a year ago - but it was December 15th. And everything up to that point and honestly with any kind of open enrollment activities has been very smooth.

One of the things that we've done - and I cannot remember if I said this at the last TAC, so, I'm sorry if I'm repeating myself - but one of the things that we did since we were kind of late getting open enrollment materials out to members was, from the date that open enrollment ended, for ninety days, we're allowing additional flexibility for members to be able to change their MCO even outside of open enrollment because normally what would happen in a normal world is if you change your MCO or you come in new and pick an MCO, you have ninety days to change, but, then, after that, you're kind of stuck until the next open enrollment.

But what we've done is this allows everyone but this includes those that did not change their MCO during open enrollment, they still can change through March 15th. And, so, it's not a dedicated open enrollment. We're just allowing that flexibility to them.

DR. SCHUSTER: So, that's ninety days from December 15th.

MS. BATES: Or 16th through March 15th.

MS. MUDD: Members were sent that information that they have until the 15th?

MS. BATES: It's all posted. Just because it's not a dedicated open enrollment, we did not send out any of that, but we've tried to post it far and wide. I know that KDH and others have posted that. You all are welcome to do that as well.

What I would caution you is be careful. I mean, if you want to run some language by us, just do that, so that way you're not saying things that might be outside of what's the actual reality because it is not an extension of open enrollment. We're just allowing the flexibility.

And as far as lawsuits, all of that stuff is ongoing. Nothing has ended; but right now from the Department's perspective, we let the legal teams deal with that, and right now we're six MCOs. We have everybody in and we were able to implement the contracts on 1/1 fairly quietly including SKY.

DR. SCHUSTER: Right, because you really have seven programs, I guess. You have six MCOs but one of them has that SKY Program for the youth.

MS. BATES: That's right.

DR. SCHUSTER: And is that a separate contract, I assume?

MS. BATES: It's just an additional section of the Aetna contract. So, it's one contract; but for them, it's going to be a separate program.

DR. SCHUSTER: Right.

MS. BATES: And I think Kelly is on, too. I don't know that we have SKY on the agenda, but I believe, Kelly, don't you all look at that as a separate program within Aetna?

MS. PULLEN: Good afternoon. Yes, we do look at this as a separate program at Aetna and there are different and more enhanced supports and services to members that are in a SKY Program.

DR. SCHUSTER: Do you want to take a minute, Kelly, to just very briefly talk about what the SKY Program is because there may be a number of people on who are not familiar with it?

MS. PULLEN: Yes, absolutely. So, SKY stands for Supporting Kentucky Youth. And the numbers that are eligible for this, of course, eligibility is determined by Medicaid, but we're looking at kids that are impacted by the child welfare system and juvenile justice systems.

And, to date, we probably

roughly have about 26,000 members that are enrolled. And once you're enrolled in a SKY Program, everyone receives care management, and, so, that looks a little bit different from our traditional managed care world, and the care management is definitely enhanced.

So, these members receive, based on where they stratify in our tiers of complexity, they can receive face-to-face visits from our membership. They also receive weekly phone calls. In our most complex tier, the members receive high-fidelity wraparound. We do have care managers that are certified in that and are actually providing that to our most acute members. And, then, they have their care plans reviewed monthly and updated monthly.

And our complex care managers also have taken over responsibility of completing that individual health plan that was previously being done by the Commission, and, so, that's really embedded in our care planning process.

In addition to the care management services and supports, the members do have enhanced value-added benefits that are targeted towards that population.

And, then, our team also has a really robust training, education and support component where we are providing a lot of training and technical support to our partners in the system. So, that includes the Cabinet, their workforce, but also the private provider community and also any other family members and stakeholders that are involved in these youth circles of support.

So, we're really excited about the program. We did just go live a couple of days ago and we're really excited about this. So far things have been going smoothly and we look forward to working with everyone as this gets off the ground.

DR. SCHUSTER: Great. Kelly, what about the kids that are placed out of state? I know there are not many but a couple of kids, hopefully just a handful that might be placed out of state for treatment, do they fall under you all?

MS. PULLEN: If they meet the eligibility requirements and they have one of those eligible type of assistance codes, absolutely. We do have members that we're servicing that are placed out of state; and our care management team, you know, instead of providing a face-to-face visit, it's virtual but they're still providing that enhanced

care coordination to that member and actively trying to get resource to bring that member back instate.

DR. SCHUSTER: All right. Thank you very much. That was excellent on spur of the moment. We appreciate that.

I noticed that Nina asked the question I was going to ask as well, Stephanie, and that is about our understanding is that United has been assigned the Medicaid folks who are on presumptive eligibility. Is that correct?

MS. BATES: That's correct.

DR. SCHUSTER: What kind of number are we looking at there?

MS. BATES: I would have to see about getting those numbers for an official report just because the transition for 1/1, we're still making sure we have all the final numbers correct.

I think Monday is the next report that comes out after everything has been fixed, little nuances that happen when things change over, but I'm happy to get those numbers for you after we get that Monday report so you can have a more accurate number.

DR. SCHUSTER: Okay. That would be great.

MS. EISNER: Stephanie, may I also ask? The rules that have been in place approved by the Cabinet so that we don't have to get authorizations for care, we have to do a notification and so on, did that same process apply to the new MCOs as well - Molina Passport and United?

MS. BATES: Yes, ma'am, for both par and non-par.

MS. EISNER: Perfect. Thank you so much.

MS. BATES: And for those of you, par are those providers that are contracted with the MCO; but if the MCO doesn't have a contract with a provider, it applies as well.

DR. SCHUSTER: The other thing I was going to ask you about that group assigned to United, Stephanie, is, is it accurate that they cannot change that assignment?

MS. BATES: They cannot until they complete a full application to become fully enrolled in Medicaid.

DR. SCHUSTER: And presumptive eligibility is time-limited, right? Do I remember that?

MS. BATES: That's correct.

Right now, we're looking up to March 31st. So, there's two presumptive eligible periods that are allowed in a calendar year, and right now we're doing ninety days in the Public Health Emergency.

So, the first period would have been from January 1 to March 31st. And, then, the next period would be, as long as we're still in a Public Health Emergency, would be April 1st for the other ninety days.

We, of course, are encouraging United to reach out to the members to get them to go head and complete their full application, but that's ultimately what would get them to the point to where if they wanted to change their MCO, that's how they would do that.

DR. SCHUSTER: Okay. So, they are with United as long as they're in the presumptive eligibility. And, then, once they become full, if you will, full Medicaid members, then, they're treated like all the other Medicaid members and have the opportunity to change if they want to.

MS. BATES: Yes, for now. That's the decision for now. And when we say full Medicaid, and you probably are apprehensive about saying that, too, because really the presumptive

eligible members have the same Medicaid benefits. The actual benefits are the same as any others. So, I don't want to mislead anyone in thinking that they don't receive the full range of benefits.

DR. SCHUSTER: It's always been a confusing term in some ways, and I think there's confusion out there about is there really a difference. And in terms of access and benefits, there really is not.

MS. BATES: Right, and I think all of us, including me, have learned a lot more about presumptive eligible members in the past nine months than we thought we would.

DR. SCHUSTER: Yes, right. Thank you very much. Any other questions that anybody has about open enrollment or kind of our status with our six MCOs?

All right, hearing none, I'm glad you're on, Nina, because this is always your question about single medical necessity criteria for behavioral health.

MS. EISNER: And I'll be glad when I stop asking. Has there been any change on that, Stephanie?

MS. BATES: No. We still have

the same contract requirements with the medical necessity. The answer isn't any different, Nina. I'm sorry.

MS. EISNER: Thank you.

MS. BATES: I'll try to answer it in a different way the next time.

MS. EISNER: Thank you, Stephanie.

DR. SCHUSTER: So, for those who may be new, can you kind of quickly go through the history of this thing, Stephanie, because it really started with legislation that goes back to 2016. Is that right?

MS. BATES: And that was House Bill 69, wasn't it, Nina?

MS. EISNER: Yes.

MS. BATES: And Nina can correct me, but basically there was legislation - it seems like a decade ago but it was probably only like four or five years ago - but, anyway, that really called for a single medical necessity criteria. The intent, I believe, was to just have the single medical necessity criteria for certain things.

But what happened is it kind of put it in DOI's court, right, the Department of

Insurance? I don't know. I don't know if they shot it back over to us. It's gone back and forth.

And, then, we also have contract requirements with our MCOs. We actually changed the contract requirement at some point in there and we were sued. And, so, then, we had to stick with the old, at the time, the old contract language.

So, it's just been one of those things where DOI, we think DOI is in charge of it. With DOI for behavioral health, we do have a single medical necessity criteria.

But the reality is is that if you look at, outside of behavioral health, all of them, right, InterQual, Milliman or MCG, all of the things, ASAM, just everything, each one of those, they just don't capture everything within that group and that's kind of been an issue up to this point.

But the answer to the question is that we do have a contract requirement with the MCOs on what they should use and that as of today is what they will follow.

MS. EISNER: We were able to - I mean, really, all we were trying to do was to have consistency across the various payors, and at that

time there were five, and really just trying to make it easier for providers to be able to get a consistent answer based on medical necessity of the person that they're with.

We have been able to achieve, we had then and we continue to have, for substance use disorder, for example, everyone uses ASAM. And, so, that's simpler than trying to navigate the Milliman versus InterQual.

It is what it is. I've gotten more patient as time has gone by, but I think it's still something important for us to continue to look at. It got stuck when it went to DOI and then went back to the Cabinet and then went back to DOI. And, really, that's going to happen until the lawsuit is settled, right?

MS. BATES: Right. There's so many lawsuits, it's hard to keep up with them at this point.

MS. EISNER: So, anyway, thank you, Stephanie.

DR. SCHUSTER: Stephanie, do I remember, though, that in the new contracts starting this year, that they have to post on their website what their medical criteria is?

MS. BATES: All of them should have their criteria available at all times for providers. I don't have the contract in front of me and I don't want to misspeak. I can go back and look at that to make sure exactly what the language is; but at anytime, I will say, for providers and members, if there's a service that is being requested, the criteria should be made available to everyone.

DR. SCHUSTER: If you don't mind checking because I either made that up or it was wishful thinking or I thought I heard that at a previous BH TAC meeting that maybe the new contracts were more specific about having it posted on the website.

MS. BATES: I think the problem with that, and I'll just say this, is that, so, if you look at like InterQual or MCG, those companies look at that stuff as if it's----

DR. SCHUSTER: It's proprietary.

MS. BATES: So, they would not want that to be posted or it would be limited. So, anyway, I'll go back and look and share the language with you on exactly what we have in the contract.

DR. SCHUSTER: Okay. Thank you

because that's the hardest thing for providers to go back and forth with the MCOs about, for sure. So, thank you on that.

Anybody else have anything that they want to ask or say about medical necessity?

Okay. How about telehealth? Where are we with that? And I heard the Commissioner say that DMS is looking upon telehealth very favorably in general because of the access that it has provided for Medicaid recipients to continue to get services.

And certainly in the behavioral health space, we've heard from the CMHC's and from a number of people that it has been effective in many cases, certainly not in all, and there probably are certain folks that don't do well with telehealth, but I'm just curious.

I saw that Representative Frazier had filed House Bill 140 for some changes in telehealth, and I didn't know if there had been any consultation with you all at the Cabinet on any of that, Stephanie.

MS. BATES: No. We're aware of the filing; but just from our perspective outside of that, and I'll reiterate what I said at the last

meeting, we have been pleased with the use of telehealth and how even the expansion outside of our already-expanded telehealth program has worked.

It seems to have gone really well and we do support keeping some of the added flexibilities when we can finally get on the other side of this, but right now the flexibilities are there and we plan to work with the Legislature on the bills that are filed.

We just want to make sure that we're careful that we don't inadvertently cause something, whatever that is. You know how that happens with legislation.

And, so, if we ask questions or have comments, it isn't to keep from covering things. It's more just to head that off at the pass, right, on the other side of it.

So, things like telephonic services have worked really well, however, we still have to, outside of the flexibilities we're giving now, follow correct coding and providers have to follow their licensure requirements and all of that, but we just want to make sure that from that perspective that we're good to go on the other side.

We completely support

telehealth, I would say. This time last year, we didn't even know we were going to be where we are now and I don't know that I would have said the same thing last year but we've been pleasantly surprised with telehealth.

So, we're at the table and definitely will weigh in on the legislation.

DR. SCHUSTER: Thank you. I did take a quick look at it. It does seem to include the telephonic flexibility, and it certainly makes clear on both the Medicaid side and the commercial side that services delivered by telehealth should be reimbursed at the same rate as if they were delivered in person.

And it also seems to be careful not to put criterion in. Some of the insurers and MCOs would have criteria like you had to see the person face-to-face before you could do telehealth and some of those kinds of things.

I think the other thing that we've been concerned about - and this is not on the Medicaid side but on the commercial insurance side - is some of the insurers were requiring providers to only use their platform, and, then, they would put restrictions on in terms of training to use their

platform and sometimes at a reduced rate. So, we certainly want to avoid that kind of thing, but I would encourage you all to look at that. That's House Bill 140. It was just filed yesterday.

There were a slew of bills. I was up listening to the Georgia election results with one ear and trying to sort through hundreds of bills that were filed in the House and Senate last night.

Anybody have any questions about telehealth or any comments about it?

I do think there were several licensure boards that were requiring additional CE's or not allowing certain levels of practitioners to use telehealth, and I believe that all of them have changed their regs and have loosened that up because we heard about some of the difficulties from some of those providers. Again, hopefully, that would continue to be the case past when the State of Emergency ends. All right. Thank you.

And I know that the waiver for SUD services to incarcerated persons has now gone to CMS, and I believe that the deadline for comments over there is either this Friday or Saturday. I can't remember if it's January 8th or January 9th. Do you have anything else on that, Stephanie?

MS. BATES: I do not. Leslie Hoffmann and her team have been doing that. Is there anyone on that can update?

MS. HUGHES: Stephanie, I thought I had invited Leslie. Let me look because if she's not on, it's possible that I failed to invite her but I thought I did.

DR. SCHUSTER: She's been on in the past, and I don't know that there's a whole lot. I think it's out of the State's hands at this point.

MS. BATES: It is. I don't think there's much of an update. I don't see her on there, Sharley. So, what I'll do is we'll provide a written update for you, Sheila, if that's okay. I don't think it's much but we'll do that for you.

DR. SCHUSTER: All right. I would appreciate that.

MS. HUGHES: Sorry about that, guys.

DR. SCHUSTER: That's all right, Sharley. And I think she's on my list. I have a group of DMS folks that I remind about our TAC meetings, too, and I'm pretty sure that Leslie is on that. She may have had a conflict.

Many of you all who are

participating in the call get my updates through the Kentucky Mental Health Coalition and some of you get them through Kentucky Voices for Health, and both of us have been posting about making comments.

In fact, KVH has a Comment Collector, they call it, that makes it very easy for people to make a comment and, then, they gather those up and will send them on to CMS because I think it was a matter of clarifying on a couple of cases to make sure that people were not being held in incarceration to finish treatment.

And we know that that's not the goal in any sense, and Leslie has made that very clear, but we wanted to be sure that that language was changed to make sure that that came across.

And I think the other thing, and they did not change this because they feel like it's an SUD waiver, they're making the requirement that the person have a primary diagnosis of a substance use disorder.

And, so, for people with co-occurring disorders, it would have to be SUD first and an SMI, if you will, or a mental health issue second. And I will tell you as a clinician that that's a very arbitrary way of looking at the world.

Co-occurrence is co-occurrence.

And my argument and my comments on behalf of the Mental Health Coalition were if we really want to get to all the people that have a substance use disorder and end up in trouble with the law, that we shouldn't be splitting hairs about whether it's a primary diagnosis or a secondary diagnosis.

So, that was my comment and I think it was plainly rejected by DMS because they feel like the primary has to be the SUD.

Any other questions or comments on that?

All right. Let me talk about a couple of things that have been already filed in the General Assembly, and I had hoped to get a little separate list for you all but I'll send it out in writing.

Many folks that are on this call have been concerned about what's called conversion therapy which is not therapy. It's a discredited attempt to change the sexual orientation of a youth and has resulted, unfortunately, in many, many suicide attempts and sometimes completed suicides by youth who are subjected to it.

So, this bill has gotten some traction in the last two years and there are companion bills. Senator Alice Forgy Kerr has filed Senate Bill 30 which is the ban conversion therapy bill over on the Senate side.

And, then, Representative Lisa Wilder, who is the only licensed mental health professional in the General Assembly, has filed House Bill 19 over on the House side, and both of these would give the licensure boards the necessary statutory authority to discipline licensed professionals who engage in conversion therapy, and, unfortunately, there are licensed mental health professionals that engage in the practice.

Senator Kerr calls it conversion torture which is probably a much more apt description.

Senator Alvarado has Senate Bill 21 which is a mental health treatment bill and it really is a combination of two different bills that got some traction in the last Session but didn't pass. One was a transport problem that hospitals were having about youth where they were unable to get a child on a voluntary transfer transported from a hospital that did not have a psych unit to one that

did. And partway there, somebody changed their mind and tried to get out of the car or all kinds of things happening and we're trying to provide a safe way to transport youth in those situations.

The second part of it is a piece of legislation that a number of us have tried to get passed for several Legislative Sessions and it has to do with homeless youth ages sixteen to seventeen who are in need of mental health care and have no one to sign for them to give permission to treat, and this would allow unaccompanied, they call them, youth who essentially are not residing with a parent or guardian the ability to access mental health treatment, and we think it's just really an important issue that needs to be addressed.

Senator Alvarado and Representative Moser have companion bills that would prohibit prior authorization being required for what we call medication-assisted treatment, and this is treatment of persons with substance use disorders that are being treated with Suboxone, for instance, or some of the other medications to deal with their addiction.

Prescribers have to have a waiver from the DEA, Drug Enforcement Agency, to be

able to prescribe MAT and they're having problems with the MCOs approving it.

So, that's on the Senate side is Senate Bill 51, and on the House side is House Bill 102.

And, then, Senator Meredith, Steve Meredith and Ralph Alvarado have a bill to prohibit copays in the Medicaid Program which we know that DMS is supportive of and tried to do.

And because of the statutory requirement that there has to be at least a minimal copay, we got into this kind of work-around in the current regulation. So, that's Senate Bill 55 and that might be one that you would be interested in looking at.

Also, on the House side, Representative Moser has come through with a couple of things that we've worked on and we worked on last Session that didn't get passed. One is a mental health parity bill. That's House Bill 50. It came to us from the Kentucky Psychiatric Medical Association. They've been doing a national push and they have an excellent consultant that has been working with us.

We want to strengthen the

parity bill that we passed in 2000 here because we know that it's on the books but the insurers and MCOs are not always following it.

So, this would be a requirement for them to put into writing annually for the Department of Insurance how it is that they are meeting the federal parity requirement. So, that's a high priority for the Mental Health Coalition. That's House Bill 50.

She also has a bill, House Bill 53, that would add a MAC member, a member to the Medicaid Advisory Council that would represent Justice-involved Medicaid recipients. And we know that there are a number of them usually around, as Mike knows, around substance use disorders.

So, that would add a MAC representative and then, create a TAC, a Technical Advisory Committee, for that group, but it's probably a TAC that we would work closely with because obviously we're in the behavioral health area.

Representative Rachel Roberts and some co-sponsors have a really interesting bill. I don't know whether it will go anyplace or not but it's a fascinating concept. It's House Bill 77.

And parallel with getting an

annual physical from your insurer with no copay and usually no cost, this would be an annual mental health exam to be delivered by a licensed mental health practitioner in the state at no cost to the consumer.

So, it's really a fascinating idea and it makes a whole lot of sense to have kind of a baseline and, then, an annual kind of wellness check, if you will.

MS. MUDD: And this is like an annual exam?

DR. SCHUSTER: Yes.

MS. MUDD: And I'm assuming, what I think would be great obviously is to access the ACE's score. I'd be interested to know what that would look like. I mean, I hope it's more than just five minutes, are you feeling suicidal? Okay, good. You're good to go.

DR. SCHUSTER: Yes. Or for those of you who are as old as I am, you get the annual Medicare of three questions - are you suicidal, do you drink, and I forgot what the other one is, but it's pretty cursory.

I think the language in the bill actually, Val - and, again, I will send you out

a written list with the links to all of these when we get off the call - well, don't expect it this afternoon but sometime in the next couple of days - I think it calls for an examination of up to forty-five minutes for a wellness check. And I do agree with you that some history is going to be really important and the ACE's and so forth.

This is not so much behavioral health but it's something that the Mental Health Coalition, the Psychological Association and a number of mental health groups have been behind and that's to ban corporal punishment in the schools.

This is House Bill 134. Steve Riley in the House has it. He's a former educator, retired now. And we do know that this is not good for kids. Corporal punishment has been shown to have some pretty negative mental health effects and we feel like there are much better ways of monitoring and shaping behavior than using corporal punishment.

I mentioned before House Bill 140 which is Deanna Frazier's bill on telehealth.

And this bill has been kicked around for ten years or so, a bill by Representative McCoy to prohibit the death penalty for persons with severe mental illness, and that is House Bill 148.

And, then, Representative Moser has House Joint Resolution 7 which would establish an SMI or a severe mental illness task force and would have on it all the relevant legislators, representatives of the Cabinet and all and the Education Workforce Cabinet, as well as Housing and special medication expertise.

So, those are the ones that are out there already. There will be many more, I'm sure, coming up but I will get that list out to you.

Does anybody have any questions about those or have any others that they know are in the offing around behavioral health issues?

And, obviously, the other thing to pay attention to is the budget. We're not used to doing a budget in the Short Session.

So, we're always worried about the funding for the Department for Behavioral Health, Developmental and Intellectual Disabilities, but we're also worried about the pension contribution for what we call the quasi-governmental agencies which include all of our community mental health centers, the rape crisis centers, domestic violence shelters, and children's advocacy centers because if that rate is not frozen at the current rate of about 49%

contribution, we're really looking at bankruptcy for a number of those agencies.

So, that's something that we work real hard on and we're not used to doing a budget every year, but they only did a one-year budget in 2020 because of the COVID and not knowing what the impact would be.

So, we're hoping that there are no cuts. Remember, if you don't get an increase of at least 2 or 3% for cost-of-living, you're essentially getting a cut every year. So, a continuation budget is not a continuation.

And, then, if you get any kind of cut on top of that, that would affect Medicaid, for instance, would affect DCBS, would affect DBH. So, we worry about those things.

And I will tell you that contact with Legislators is going to be very difficult because no one is going to be allowed in the building.

We have on the Advocacy Action Network website, we've been posting updates on accessibility issues and sending those out. So, if you want to get that and don't have it, you can go to the AAN website or you can send me an email at

kyadvocacy@gmail.com.

I don't think that Diane Shermer is on. She was going to tell us about workgroup recommendations on the ABI waiver. She was actually strongly encouraged to go get her COVID vaccination and I told her that was more important for her livelihood than being on this call. So, we'll have to get that report next time.

Do any of the members of the TAC have any recommendations that we need to make for the next MAC meeting or any suggestions for any others of you? I didn't have any coming in to the meeting. We seem to be limping along fairly well right now, maybe not even limping so much.

And we enjoy the good working relationship, Stephanie and Sharley, with the Department for Medicaid Services for sure, Jessin as well.

MS. BATES: We do, too. Let us know if you need anything, Sheila, and I'll send over the things that I promised to you. And, of course, everyone on the call knows you can always reach out to me.

DR. SCHUSTER: You're on speed dial for a number of people. So we appreciate that,

Stephanie. And, Sharley, we again appreciate your help in getting things out to us and I try real hard to get those out, then, to this group.

Again, I would remind you, if you're not getting my emails regularly, to put them in the Chat and I will make sure that I get them to you.

Any agenda items for our next TAC meeting? And, Sharley, the agendas are a little bit more open now because they are regularly-scheduled meetings?

MS. HUGHES: Yes. They're regularly-scheduled meetings now because they were originally scheduled as a Zoom meeting. So, you do not have to stick with just the agenda items this year.

DR. SCHUSTER: Okay. All right. That's helpful and we did elaborate on a couple of things. So, I'll do the same thing I've done before. I always send the draft agenda to the voting members of the TAC to get their input.

And, then, typically I send it out to you all who are in my email for the Behavioral Health TAC and you all are welcome to ask questions or to suggest things for the agenda. We're happy to

have that.

The next meeting of the MAC, and that will be by Zoom, and they meet on the last Thursday of the month, just to remind you - January, March, May, July, September and November, except in November, they don't meet on Thanksgiving. So, last Thursday of the month.

MS. HUGHES: Sheila, it's not necessarily the last Thursday. It's the fourth Thursday.

DR. SCHUSTER: Oh, okay. Good point.

MS. HUGHES: Some months have five weeks.

DR. SCHUSTER: Good point, Sharley. It's the fourth Thursday except in November when it's the third Thursday.

And our next meeting, and, remember, we moved to the second Wednesday of the month. We had this one already scheduled, but we didn't want to be in conflict with the Children's Health TAC.

And I'll be sure to send that table out. I think I sent it out to you all earlier but I will send I out again.

MS. MUDD: And they're from 2:00 to 4:00, right?

DR. SCHUSTER: The next one will be 2:00 to 4:00 because they will be in Session. And then we'll go back to our usual time of 1:00 to 3:00. Thank you, Val, for that reminder. So, March, and, then, in May, July, September and November, we'll be back 1:00 to 3:00.

MS. HUGHES: And just to remind everybody, Sheila, that if you can't find the Zoom link, it's for your meetings. For the Behavioral Health, you all have your own website for the DMS website.

So, the Zoom meeting links and so forth are on that website, and also the Zoom link for the MAC meetings are on the MAC website. So, if you're having trouble finding the correct Zoom link, that's where you can find it.

DR. SCHUSTER: Right. And you know you all can text or email me and let me know if you're having any problems.

So, if there is no further business to come before the BH TAC, we will adjourn in record time.

MEETING ADJOURNED